Special Medical Advisory Group (SMAG)
Minutes

May 14, 2007

Welcome and Introductions

The Chairman, Dr. Thibault, began the meeting by welcoming the group to the SMAG Fall meeting and keying up the day's agenda topics which included environment of care issues in light of the recent Walter Reed Army Medical Center (WRAMC) story. Roundtable introductions were made and Dr. Thibault welcomed new members particularly Dr. S. Ward Casscells, the new Assistant Secretary for Defense for Health Affairs at the Department of Defense and Dr. Charles Grim, Assistant Surgeon General and Director, Indian Health Service, Department of Health and Human Services. The intent of the meeting was to present various issues to the Group and solicit their advice. He then turned the meeting over to Dr. Kussman, the Acting Under Secretary for Health (USH).

The Washington Scene

Dr. Kussman began with an open discussion of the Washington, DC environment in light of the recent story on Walter Reed Army Medical Center. There has been significant interest and scrutiny regarding the perception of care veterans receive after they return from Iraq and Afghanistan. The perception is that VA care is second-rate, VA polytrauma centers are at maximum capacity and veterans and their families would receive better care from a civilian agency. VA has instituted a program where if a family is dissatisfied or upset with the care they receive from VA, VA would initiate a second opinion. In spite of the negative press, VA has also received a tremendous amount of support from Veteran Service Organizations.

In addition, the research industry has risen up and partnered with DoD and with VA for new technology, and it will help this new population of veterans dramatically. Their expectations are different – they want to rock climb, run marathons and play hockey. If VA does not have access to this new technology, it will work with DoD, who may have partnerships with private research companies, to acquire this technology for veterans.

Other concerns include silent illnesses such as Post-Traumatic Stress Disorder (PTSD) and Traumatic Brain Injury (TBI). The real issue is mild and moderate TBI. Although the majority of mild and moderate TBI cases improve, some blast injury-related TBI is different. DoD has started to identify returnees and note in their record if they were exposed to a blast. VA is initiating research with DoD to follow this population longitudinally toward establishing a registry. The percentage of returnees with PTSD is probably 10-15 percent. A higher percentage have readjustment reactions. VA and DoD are cognizant and will take precautions to avoid stigmatizing this population.

VA is continuing to invest resources to make mental health services available to returning service members such as $3 million in FY07 toward mental health, which does not include funding for vet centers. VA is increasing the number of vet centers by 23 this year for a total of 232 vet centers around the country.

In addition to hiring 100 Global War on Terrorism (GWOT) outreach counselors, with the Secretary's approval, VA also plans to hire 100 transitional patient advocates, as ombudsmen, to support returning service members and their families. They will follow

them longitudinally starting at the military treatment facility (MTF) to VA and help service members and their families navigate both health care systems.

Related to the recent story on WRAMC, VA proactively assessed its health care facilities for environment of care deficiencies. Ninety percent of the items requiring repair were the result of normal wear and tear. Mold comprised the largest percentage of the repairs; two percent or less of the mold was located in the buildings. Network and facility leadership will provide increased oversight by assembling both network level and facility level teams to perform unannounced visits to reinforce to facility leadership the importance of conducting regular rounds in their facilities. Repairs to facility infrastructure will take a longer period of time to resolve, but currently there are no infrastructure issues that would pose any threat to patients, employees or visitors. If any arise, the expectation would be that immediate action would be taken by facility leadership. Over the next two years, a little over $1 billion will be available to VHA to address issues such as patient safety, environment and infrastructure needs.

Women Veterans Health

Ms. Patricia Hayes, Acting Chief Consultant for the Womens Strategic Healthcare Group, presented on women veterans health issues. She began by giving the group background and a summary of the women's health program in VHA. The women veterans health program began through congressional legislation in 1992 to provide gender-specific services and reproductive health care to veterans. In 1995, the authority expanded to include counseling for military sexual trauma. Some of the program's accomplishments include performance measures and goals for breast and cervical cancer screening, osteoporosis and bone density screening and mammogram screening. The goal is to move the focus beyond gender-specific care to comprehensive care of women and women's health as a subpopulation of all veterans. Demographics show the majority of women VA serves today are under 55 and compared to their male counterparts, have more education. In 2006, approximately 239,000 women utilized VA services and the number seen in VA facilities is anticipated to grow. Since 1999, VA has the authority to provide obstetric care, specifically prenatal care through delivery. VA does not care for newborns. In FY 2000, VA delivered 500 infants; in 2005, VA delivered over 1,000 babies.

Current challenges include avoiding teratogenic drugs in sexually active women who are planning families, in light of the significant prevalence of mental health diagnoses and most psychotropic drugs are dangerous to fetal development. Also, more homeless veterans are women due to two factors: there are more female soldiers and there may be a prevalence of sexual assault and economic factors. VA is working to establish programs and partnerships with communities to have programs for women with children. VA needs additional competent and interested primary care womens health providers. Women who are seen in the VA have a high prevalence of diabetes and obesity that complicates cardiac risk. Recent data shows that VA is deteriorating in our earlier successes of breast cancer screening and in general preventive health screenings, however VA will ensure that women are receiving the appropriate follow-up care. The womens health program will also need to look at the availability for colposcopy for abnormal paps and HPV-positive results. The next steps include increasing education efforts geared towards primary care providers, increase access to mental health providers, including therapists for military sexual trauma counseling and depression as well as breast cancer screening and risk avoidance in medications of women of child-bearing age.

Working Lunch: OIF OEF Issues

Dr. Barbara Sigford, National Director for Physical Medicine and Rehabilitation Program began with a presentation of polytrauma and TBI issues. She began by providing a brief overview of the VA Polytrauma System of Care. This system of care is comprised of four facility-based components and support elements. Currently, VA operates four regional Polytrauma Rehabilitation Centers and 21 Polytrauma Network Sites as well as 76 polytrauma support clinic teams. These rehabilitation teams include, at a minimum, a physician, a physical therapist, occupational therapist, speech pathologist, psychologist, social worker and a nurse case manager. Underlying all of this are elements of family support, case management, benefits management and records management, which have become areas that are very important to move patients through the continuum of care.

Also, a traumatic brain injury tool has been developed and was implemented April 2, 2007 by an interdisciplinary team with expertise from clinicians in VHA, DoD, the Defense Veterans Brain injury Center as well as the private sector. The screen asks four questions:

1) Was there exposure to a mechanism that would have caused a brain injury (e.g., a blast or explosion, motor vehicle accident, gunshot wound around the head or neck)?
2) Were there immediate signs or symptoms of a brain injury (e.g., dizziness, loss of balance, loss of consciousness, alteration in consciousness, confusion, loss of memory)?
3) What were the post-concussive symptoms that have developed, since developed or worsened since the event (e.g., headache, irritability, problems with sleep, memory or cognition)?
4) Are these symptoms ongoing?

One of the most important elements within the polytrauma system of care is lifetime case management. There is clinical case management through rehabilitation nurses and psychosocial case management through licensed clinical social workers. The regional Polytrauma Rehabilitation Centers, Polytrauma Network Sites and polytrauma support clinic teams share best practices to decrease variability across.

Afterwards, Ms. Jill Manske, Director of Social Work, presented on the case management aspects of care for returning OIF OEF service members. The Polytrauma Centers have a very strong case management system. VHA has a ratio of one social worker case manager for every six patients in all four polytrauma centers given the complexity of the patients, healthcare and family issues.

These VHA case managers make contact with the patients and the family before they're transferred to the VA when they are still at the DoD Military Treatment Facility to coordinate the transfer to one of the Polytrauma Centers before they arrive. The case managers also arrange for lodging for the family, if the family member is coming with the patient to the polytrauma center. VA has Fisher Houses are two Polytrauma Centers, at Palo Alto and Minneapolis. A third Polytrauma Center Fisher House will be finished in Tampa in June this year and the Fishers are breaking ground at the Richmond Polytrauma Center. By the end of the year, VA will have Fisher Houses at all four Polytrauma Centers. In the interim, donations from a variety of sources provide hotel lodging for families at Polytrauma Centers without Fisher Houses or those with overflow.

The case managers are on-call 24-hours a day and have pagers. They meet with the treatment team and address any family issues and involve and engage the patient and families in treatment planning. It's important to carry out care in the community and VHA's goal is to get people back home or as close to home and their extended support systems as possible. For individuals who are not able to return home (a fairly small population), VHA is able to provide long-term care either in a community facility or in a VA facility, with long-term care capabilities, if one is located nearby. For individuals who are able to return to work or school, VHA has specialized programs such as vocational rehabilitation, educational rehabilitation and compensated work therapy.

Finally, Ms. Manske emphasized the importance of long-term follow-up and recognize that once patients are discharged, they should routinely come back for follow-up evaluations and management. New treatments and technology are constantly being developed, and VHA will continue to assess and offer new treatments when patients return for care.

Ethics Briefings
Jonathan Gurland provided the annual Spring ethics briefing to SMAG members.

General Remarks by Secretary Nicholson
The Secretary thanked the SMAG for their contributions to VA and work in providing counsel on caring for the newest generation of veterans.

General Discussion

The Chair thanked everyone for their participation.

SMAG meeting concluded at 2:39pm.